COUNTY OF LOS ANGELES – DEPARTMENT OF MENTAL HEALTH
PROGRAM SUPPORT BUREAU – QUALITY ASSURANCE DIVISION
CORRECTIVE ACTION PLAN (CAP) FORM

Legal Entity#._____

Please check one of the following boxes and complete the CAP:		Question No. _____ from the **CPQAR**	
☐ Fully implemented	☐ No change from last report	☐ Partially implemented	☐ Not implemented
Correction: Issue to be corrected			
Action: Specific steps to be taken to address issue to comply with DMH regulations			
Timeline: Anticipated completion date			
Barriers: Challenges to timely implementation (if applicable)			
Please check one of the following boxes and complete the CAP:		Question No. _____ from the **CPQAR**	
☐ Fully implemented	☐ No change from last report	☐ Partially implemented	☐ Not implemented
Correction:			
Action:			
Timeline:			
Barriers:			
Please check one of the following boxes and complete the CAP:		Question No. _____ from the **CPQAR**	
☐ Fully implemented	☐ No change from last report	☐ Partially implemented	☐ Not implemented
Correction			
Action:			
Timeline:			
Barriers:			